February 17-19, 2010, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington, D.C.
February 17-19, 2010

Meeting Summary

The 64th meeting of the National Advisory Committee on Rural Health and Human Services was held February 17-19, 2010, in Washington, D.C.

Wednesday, February 17, 2010

The Committee members present at the meeting were: Larry K. Otis (Vice Chair); Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; B. Darlene Byrd, MNSc, APN; Sharon A. Hansen, Ph.D.; David Hartley, Ph.D., MHA; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; A. Clinton MacKinney, MD, MS; Karen R. Perdue; Robert Pugh, MPH; John Rockwood, Jr., MBA, CPA; Maggie Tinsman, MSW. Mr. Dennis Dudley attended representing the U.S. Administration on Aging.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Jennifer Chang; Heather Dimeris; Carrie Cochran; Laura Merritt and Kai Smith.

HHS Update

Mary Wakefield, Administrator
HRSA

Mary Wakefield began by thanking the Governor for his leadership and talking about the importance of the advisory committee. This committee is used as a model in HRSA and other operating divisions outside of HRSA. She noted that it had not been long since she was a member of the committee and she valued that time because the issues are very important to her. She had the privilege to host a visit from the committee to North Dakota for a site visit. She said that she understands the committee is used to shape the work for the coming year. These are very interesting times in Washington D.C. and it is a good idea to stop and get a sense of what the issues are and how they might unfold going forward. She said that stopping and

looking at the agenda makes a lot of sense. Dr. Wakefield apologized that Dr. Dora Hughes was not able to make it to the committee meeting. She noted that Dr. Hughes is heavily involved in rural issues and very much wanted to attend the meeting. She told the committee that she would share with Dr. Hughes the conversations that occurred. In her absence, she was focusing her remarks on what Dr. Hughes would have shared from a HHS perspective. She will also speak about Health Resources and Services Administration's agenda as it relates to the work that the committee is doing.

Dr. Wakefield spoke about advisory committees and her perspective on their importance. They are the nexus between the field in an organized way and policies and programs that are operationalized at the federal level. They do not always have a tremendous amount of influence. It depends a lot on how they execute their work, how focused they are in their work and whether or not their work is actionable. Fundamentally, they can play an extremely important role. They provide practical advice, sound counsel and bring their expertise to the table. All of that helps to insure that the policies and programs that are administered are as affective, efficient and as relevant as possible. It depends not just on the message but how the message is packaged. For your work, that means that what you bring to the table is especially important. When we talk about rural health and rural human services, we know that a "one size fits all" approach does not work. When we talk about health care at large, or talking about some facet of a reimbursement policy, an issue about measuring quality, it might fit nicely or may not. It may be more apropos to urban human services and less so for rural human services or health issues. The annual report that the committee produces is an effective way to engage us in our work with pushing policies forward and implementing programs. HRSA needs your expertise and best advice about how to improve what we are engaged in.

She noted that it was just over a year ago that she accepted the President's invitation to join his administration, and take over the helm of the Health Resources and Services Administration. She did it in part because she saw it as an opportunity to contribute to a range of programs. All of HRSA's programs are very important. It was particularly appealing because of the part of HRSA that engages a rural health focus. The Office of Rural Health Policy, the part of the agency that the committee advises and that the committee advises the Secretary about. She said that was an attractive reason for her to leave a tenured job at a university that was comfortable. It was attractive to come and help to execute an agenda that would help all of the programs to meet the mission of HRSA but with a particular eye toward rural health. She said that she comes from a rural community much like many of the committee members. It is a town of about 7,500 people. It was a town with a lot of the same health challenges that there are today across rural America. Just as the advisory committee provides the members with an opportunity to engage, influence and inform, she took her current position because it provides

her with an opportunity and a special set of expertise to bring to the rural health agenda. It is operationalized through the Office of Rural Health Policy. She borrowed a phrase from President Obama. She said this is an unprecedented period of time in thinking about health care systems and reform. Dr. Wakefield said the President's view is that the work should not result in more of the same. Her view in taking this job is that her work should not result in more of the same. It should be moving an agenda forward, more efficiently and effectively. It is always building on platforms that are able to be pivoted off from, but not to continue the status quo. We need to move a sharper, smarter agenda forward. Dr. Wakefield stated that it is also the work of the committee. She said that it is her work as an HRSA administrator and also the committee's work. We are at an unprecedented junction in terms of healthcare. For the past year we have been involved in all sorts of activity around healthcare reform, debate and dialogue while also implementing major features of The Recovery Act through the Health Resources and Services Administration. This has provided us with opportunities, challenges and with some progress and more progress hopefully to come. The advisory committees can help execute the agenda while moving forward. She said that she would talk to the committee about what HRSA is doing. What HRSA is doing has implications on what the committee does. She said she would speak across HRSA's portfolio of programs with course of the Office of Rural Health Policy. She then noted that ORHP is expertly led by Tom Morris. Dr. Wakefield said that there is a wonderful set of leaders across the various bureaus and offices at HRSA, but there is no one who is better than Tom Morris. There are a few as good but no one that is better than Tom. The program is extremely pivotal. Carrie Cochran, Heather Dimeris, and others who work with ORHP are some of the best staff that you can wish for in a federal agency. However, we also have other parts of HRSA and let me make comments about those.

HRSA supports care for about 24 million people and touches the lives of about 24 million patients nationwide. A lot of the work is done through partnerships. HRSA certainly does not do it alone. Federal government does not act in isolation. It is through partnerships with state and local governments and with grantees to improve, for example, maternal and child health. Through the health center grantees, there are 7,500 clinical sites. Hundreds of colleges and universities engage with HRSA on healthcare workforce programs. There are other grantees including rural grantees, critical access hospitals, rural health clinics and more. There is a lot of activity, and there are many programs in this roughly, 7.2 billion dollar agency that has recently added to it another 2.5 billion through The Recovery Act. The health centers have been a major part of The Recovery Act and been in the news a lot lately as has workforce development. Much of that attention is coming as a result of recovery act resources devoting 2 billion dollars to health centers and 500 million dollars to healthcare workforce. The congress and the Administration have put this together and HRSA is deploying. The funds from The Recovery Act have made a long over due and very important down payment on workforce.

The first part of the money infused into primary care was about 300 million dollars. It is doubling the field strength of the National Health Service Corps. The 2010 appropriations have added an additional 7 million dollars for the National Health Service Corps over 2009. This takes the funding level of the National Health Service Corps for 2010 up to 142 million dollars. There is an immense infusion through The Recovery Act sustained by congress and the Administration for the National Service Corps workforce for 2009 and for 2010. Those resources actually continue into the 2011 budget. More than 6 out of 10 of those providers take rural assignments. That is how important this investment is. There have been tremendous numbers of vacancies across the United States in rural and urban areas. Certainly in rural areas the National Service Corps is one of our major programmatic levers to drive more individuals into underserved areas. It might be of interest for the committee to know that within 6 weeks of the announcement of The Recovery Act money available to the National Health Service Corps, there were more than 2,000 applicants applying for admission into the corps. Dr. Wakefield stated that if you build it they will come and they are coming. This is all good news for HRSA, and it has required HRSA to ramp up exponentially in that area. That had been a part of the operation that was anemically funding historically, and it has been turned around rapidly. In fact, the 2,000 who expressed interest in the first 6 weeks is about equal to the number of new clinicians who are being sent to rural hospitals, clinics and public health agencies under the expansion of the National Health Service Corps. That is a big enough number to be felt on the ground after years of underfunding of the program.

The Recovery Act has also added 200 million dollars to colleges and universities, again after years of defunding of HRSA's Title 7 and Title 8 health workforce programs. Whatever shape and direction health reform takes; underserved communities and populations are typically at the greatest risk. They are almost always the most fragile when the health professions ranks grow thin. Rebuilding workforce is extremely important. HRSA are not waiting for health care reform to move that agenda. Rebuilding the workforce has been a top priority for this Administration and the congress. The committee's work on primary care issues and the 2010 report to the Secretary will absolutely be timely in forming dialogue going forward. Beyond The Recovery Act, the President's 2010 budget also created the improving rural health care initiative. That includes requests for continued funding of HRSA's core rural health programs. The conference committee has honored that request with approval of about 174 million for HRSA's Office of Rural Health Policy. The President recently released his 2011 budget that continues the support of The Improving Rural Health Initiative. The President's initiative is about more than just our traditional programs. It is also about FLEX and outreach in the state offices of rural health. It calls for HRSA to marshal our broader programs that are important to rural communities such as the Area Health Education Centers, telehealth and the 340B discount drug program and make sure that rural providers are tapping into that array of programs as well. This is about ORHP's

programs and portfolio that the committee oversees and makes recommendations about. It is also about leveraging the rest of HRSA's programs so that they are driving their resources into both rural and urban areas.

Dr. Wakefield said that when she thinks about rural health, she does not just think about ORHP and the portfolio programs. She thinks about how every single one of the programs across HRSA can and is executing its resources to make sure that they are touching rural populations. There is a lot going on for 2010 and a lot of ideas that can be considered this year as the committee starts to develop the agenda that is being focused on during the meetings. She said that she would like to offer up just a few ideas for to think about against the back drop of what she had just shared. It may be worth the committee giving a critique of the approach that is outlined in the Improving Rural Health Care Initiative. It is the President's initiative but input and critique of it is invited. She asked the committee members to look at what works and what is missing from the agenda. Dr. Wakefield stated that staff provided members of the committee with an agenda. They were also given a budget narrative that accompanies the initiative. She asked them to look at it and help think about what is there and what is not there and what should or could be. She stated that would be a useful starting point. In terms of specific HRSA programs. Ideas about how HRSA's programs can better meet the needs of rural populations are always welcome. So what would work in terms of Community Health Centers? Community Health Center's program is not inside ORHP, but it is inside HRSA and the committee's ideas would be helpful. What does not work about the way the program is executed or what could make it more affective for rural communities. She wants to hear from the committee about what HRSA could be doing better within the National Health Service Corps. She said she spoke about the resources that are going there but did not mention that HRSA is making significant changes in that program. The program a year from now is not going to look as it did a year ago. HRSA does not like a lot of the way it has been executed lately. This is not because people have not been doing a good job but because it needs to be moved into the 21st century. HRSA is driving a lot of change with great leadership to that program. They want to make sure that the change fits with the needs of rural communities. Note that the National Service Corps is in the process of being morphed into something a lot different than it has been over the last few years. It is a new program and needs new ideas. All good ideas do not come from inside of the federal government. Lots of them do, but not all of them do. It would be worth while for the committee to think about that program. What can rural programs with in ORHP do and do differently such as FLEX or outreach? Dive into the statutes and program guidelines and identify challenges and offering solutions. HRSA's resources need to be leveraged and programs thematically. It is not a case of HRSA's programs being addressed only through ORHP. What else can HRSA do for rural mothers and rural kids through our Maternal Child Health Program? What else can HRSA do on behalf of individuals residing in rural areas with HIV and AIDS? There is the Ryan White

program within HRSA. There are lots of opportunities to help make sure that rural is being looked at in depth where it matters, not just within OHRP but our other HRSA programs as well. The challenges spread beyond just HRSA's portfolio programs. Dr. Wakefield said that rural communities are reliant on programs and policies that exist across HHS. So when the committee thinks about where to focus the energy in the coming years, it is ORHP and HRSA and also within and across HHS. She stated that the committee is making recommendations to the Secretary of HHS. The portfolio of programs can become very important even beyond ORHP's programs.

Health reform has been a key priority as HRSA goes forward over the past year and also moving forward. The goal is to expand coverage and reducing healthcare costs. As there are elements of healthcare reform that you care to comment on and that are unique to rural communities, your counsel would be helpful. Medicare and Medicaid regardless of reform are extremely important to rural providers and populations. Many policy makers want linked payments for health services to quality outcomes. Linking Medicaid payments and Medicare payments is something to be discussed. She said that she assumed that linking payments is something that everyone in the committee agrees on. People should be paying for quality care. The committee's advice and counsel would be important in how HRSA navigates in that arena given all of the changes and circumstances that impact our rural healthcare providers and rural communities. Whether it is pay for performance or payment bundling or it's Accountable Care Organizations, there is a need to better understand the specific and unique implications of those for our small, rural providers. In terms of human services, she said she knows the committee has done some very good work on Head Start. She asked the committee to consider looking at specific services within that benefit that are particularly challenging in rural communities. Getting kids off to a strong start is critical, and we need to assure that programs like Healthy Start and Head Start are working very well in rural communities.

Dr. Wakefield noted that at the other end of the age spectrum there are also challenges. The population is rapidly aging, and that creates a need for services as the baby boom population reaches retirement age. That is particularly acute for rural communities that have a higher rate of elderly residents. So within this context, the Administration on Aging programs plays a critical role. There will be a speaker talking to the committee about the Administration on Aging programs. ORHP has been invited by the head of the Administration on Aging to brief them on rural issues. AoA cares specifically about rural elders. HRSA has been invited, and Tom is going to lead the briefing for the staff and leaders. She welcomed the committee's advice as they move forward and said it could be very helpful.

In terms of the economic down turn there are additional challenges in rural communities. The committee can look at topics like TANF and issues within TANF that have a uniquely rural

challenge. This is something that the committee has not considered before and HRSA should be thinking about. HHS also administers a low income home energy assistance program. It may be worth examining that from a rural perspective. You have heard recently about the Administration's interest all the way from the Whitehouse in childhood health, specifically on healthy weight for kids. It is a shared challenge between HHS and USDA. Clearly the first lady has been very focused on this activity. HRSA needs to know if there are particular challenges that need to be addressed in rural communities. If there are, there is a window of opportunity. HRSA can inform that there is an interest on behalf of rural kids if that is something that the committee is willing and interested to take up. There is no shortage of issues that can benefit from the committee's expertise. HRSA needs your expertise, your ideas and certainly want your suggestions.

Dr. Wakefield made some suggestions on how the committee might position their work. This will maximize the likelihood that it will contribute to policy and program as they advise the Secretary. These observations are based on her having sat where the committee members are seated now, and also being on the receiving end of accepting recommendations and pouring through them. We should be reengineering the work that we are doing at the Health Resources and Services Administration. So based on that background, here are a couple of observations. There are always challenges to offering analysis and recommendations that might be useful to policy makers. The Governor knows this very well having been a recipient from his State legislature and task forces and advisory committees. Because you are on the front lines, your input is very important. You are a very strategic linkage to help us avoid disconnects in policy and program. We need to get out of the challenges of silo mentality. There is not time for that. We do not have resources or money for that. HRSA wants the most efficient and effective way to apply the tax payer's dollars in federal programs. That is part of our job collectively. There is not time for disconnects. Resources need to be maximized. The committee's recommendations need to be sharply focused. That means tightly focused, short and concise. They need to lend themselves to be easily acted on. If they are ambiguous and esoteric, good luck. People do not have time. If they have to stop and give it a lot of thought, there are two other recommendations from another advisory committee that is going to make it easier to act on. So they need to be tightly focused, short, concise and actionable. If embedded within that recommendation is not "oh I know what to do", then the recommendation will not be helpful. If the policy maker, staff, or member of congress can not look at it and say, "I know what to do", then it is a lost opportunity. The reality is we are a wash in information. HRSA is drowning in information in some respects. There are reports, white papers, correspondence and unsolicited proposals. They are all well intentioned and generally provide useful information. The pace in Washington is break neck, and she urged the committee to use this job to think about how to focus not just on the "what" but how best to deliver messages and advice. This should be done with enough brevity to be

quickly understood without losing the importance of making points. The packaging of ideas is important just as the ideas are important. This committee works very hard as the Governor noted. They read what they are given, as he said. You serve because you want to make a difference not because you are looking for things to do. Dr. Wakefield said that is why she agreed to serve on the committee in the past.

In your reports, focus directly on the charge that you have as a committee and spend time digging into programs, provisions and regulations that are uniquely challenging to rural communities and to tie recommendations to the specific authorities that govern programs and policies. Not three steps off but dead on. The committee needs to make the policy makers jobs as easy as possible. It makes it easier for the people in leadership positions to pick up your ideas and act on them. Dr. Wakefield shared a story to illustrate her point. She noted that when she first arrived in Washington, she was asked by her colleagues in HHS leadership to come downtown for some brain storming. The President had been vocal about helping rural communities. During the meeting, they asked if this committee had any quick action items that they might be able to take away and drive immediately into the rural agenda for this Administration. She said that is how relevant the committee's work is. It does not just sit on a shelf. She is asked frequently for comments, and used their recommendations just a week or two upon her arrival on the job. HRSA staff looked through the past few years of reports and recommendations and there was some very good work there fortunately. There was also a gap there in the difficulty to be able to pick up and make actionable, quickly your recommendations. The good news is they were able to use some of the committee's work. She said that they could use even more if it were made more concrete and operationalized. Dr. Wakefield said that going forward she wants to make sure HRSA can use even more of the committee's recommendations. That is the reason she wanted to come down and spend a few minutes speaking. She wanted to tell the committee that they have an audience for their work. Dr. Wakefield said she knows it is hard not to be diffused because she wrote part of the quality section even after she worked on Capitol Hill for a number of years. She said she still was driving in some esoteric work and should have known better. It is easy to come to you and say, "Make it more precise". She said she was guilty of not being precise enough because she wanted to include all of the background information. Dr. Wakefield asked the committee not to do what she did. Precision, focus and tightly knitted information to programs, policies and regulations will allow HRSA their best shot at moving the needle on behalf of rural human services and rural health. It does not mean that ducking the big-picture issues or taking on only the easy things. Thread the needle as the committee and figure out what is the best way to go. It does mean to strike a balance between the two extremes and find the middle ground. HRSA does want to hear your suggestions about larger, cross-cutting themes. She noted that she had talked about some cross-cutting opportunities. The committee might want to think about the

larger thematic issues that are best addressed through white papers, correspondence with the Secretary, or policy briefs. Save recommendation for focusing like a laser. She said that she knew the committee would have an in depth and thorough discussion within the next couple of days. The agenda reflects that they have the right people coming together to inform their work. She looks forward to hearing the decisions in terms of the committee's agenda and to seeing their 2010 report to the Secretary and also hearing about the progress on the 2011 report. Dr. Wakefield said that the good news is that the committee has had an ear in the past to their work and certainly have an ear for their work going forward. She said she will do everything from her vantage point to Sheppard the committee's ideas through HRSA. She and the Secretary are asking for their ideas and recommendations and for the committee to make them as actionable as possible. She hopes that they are open to some of what she shared with them about ideas, the content and the packaging. There is a great window, and she is delighted to be able to execute over the next few years with them as HRSA moves their agenda forward. She thanked the committee for their time, and said it is always a wonderful opportunity to be at the National Advisory Committee Meeting on Rural Health and Human Services. She said that she would take questions or what ever the committee would like for her to do.

Governor Beasley stated that when Dr. Wakefield speaks that she carries great experience and shares so much information that is very helpful. He noted that the committee members will take to heart the thoughts and recommendations as well as the advice that is very important, from threading the needle to practical, actionable items.

Q & A

Robert Pugh thanked Dr. Wakefield and said that they are working with their Community Health Centers and National Association on priorities for the coming year. He stated that he understands that healthcare reform may not go as originally planned. Mr. Pugh said that both bills that passed the house and senate have major, important issues in terms of helping improve access to care. Community Health Centers are important for access of care to the uninsured and underserved. He appreciates HRSA's support of Community Health Centers. Workforce is an issue that keeps coming up. He noted that he had been serving on the committee for a couple of years. Medical Homes are going to have to address the issues of workforce. They have done work with the Bureau of Health Professions and the Health Service Corps Bureau on the issue. Anything that can be done to help address workforce issues in states like Mississippi and other rural states would be very helpful.

Dr. Wakefield responded that there is a nice infusion of resources into the National Health Service Corps, and they are the primary feeder into Community Health Centers. HRSA knows that they are extremely important and as Mr. Pugh suggested there were previsions on both bills

that addressed workforce. The good news is that there are resources that are being executed now. People can talk about the health system form and redesign, but there has to be a workforce in place to deliver health care services. You will continue to see the investment and interest in insuring an adequate workforce. It is not just the federal government that owns this but states and communities. Everyone has to work in partnership with other key stakeholders to meet that need. It is well understood at the federal level now, and we will cross our fingers on the 2011 budget. We hope that congress sees fit to appropriate the dollars that the President has asked for on workforce.

Clint MacKinney stated that he appreciates the "actionable" advice. When the committee asks for new money does the recommendation become less actionable? If so, how does the committee make the recommendations when they might need new money for them?

Dr. Wakefield stated that if you have recommendations that have a financial tie and will be competing with other high need areas that you can lose the policy makers attention to the issue. It is especially true if the dollars seem to be very disproportionate to what is do-able. The President, for example, has recently talked about a freeze on spending for a 3 year period of time. You have to be thinking about that and the tremendous concerns resonating more broadly around deficit and debt. While these issues are extremely important, so are others and policy members have to balance. She suggested they do not shy away from making recommendations that have financial implications if it is appropriate.

Tom Hoyer said that it is a concern that shows in the committee's report, but it is a general concern and has to do with flexibility verses specificity. Everywhere we go and see federally funded enterprises operating separately and failing to help one another, people are telling us, "Why would we help someone else unless there was a financial incentive that you give to do it". I think that we need to make coordination with other providers in the area, a requirement for continued funding. You either work together or can not have the money. We see places like a critical hospital that is robust and healthy and a medical practice that has nowhere to send pregnant women because there are money issues. This is very important. As a response to Clint's point, it is always a bad idea in this climate to ask for more money across the board. It is a much better idea, and we see this repeatedly on our trips, of saying we are giving everyone fifty dollars, but there are people who need seventy five and people who need twenty five. We really need to move this money around so that it is more affective.

Dr. Wakefield stated the point about calibrating resources to need. She agrees on the need of coordination. It should be expected that at the local level, and the Secretary expects that at the Department of Health and Human Services. She has repeatedly said there needs to be an expectation of leveraging and aligning resources. Across HRSA she is getting sign off to put that

into performance plans. There should be the expectation that you work outside your programs with other programs. Otherwise there is a silo mentality that we can not break through and it is a very inefficient way to operate. The expectation is there. We can not encourage people on the local level unless we are doing it ourselves. It is a difficult, challenging area to work on but it is a high priority internally. As you see places where we should be leveraging, for example WIC co-locating inside a Critical Access Hospital or a Community Health Center, we welcome your ideas. What can we be doing to create more one stop shops for people to take advantage of services? What are your ideas that can help us encourage that? It is a real challenge and if the committee has ideas we would welcome them.

Larry Otis said that they have the same issue that Dr. Pugh mentioned. In the health education area there are a lot of women involved and they need child care. They are having difficulty getting the Department of Health and Human Services to assist but with TANF they worked some of it in without difficulty. What you are proposing is excellent if you can encourage and direct more of that from your office. Programs need to be integrated if possible. He noted that he would like to invite the first lady to be involved in an obesity and diabetes program called Healthworks. It reaches about 25 thousand children a year. They are seeing a dramatic result in the children's eating habits but not in the parents who have the ability to purchase and buy. This would be an opportunity to have bipartisan work with a local senator in the area.

Dr. Wakefield said that one example is that they are working closely with the Department of Labor on the health workforce pipeline. When she is talking about leveraging and aligning that is what she is talking about. Really maximizing their resources in ways that may or may not have been done historically but they are trying to do now. They are working with many departments including HUD, USDA and more.

Governor Beasley thanked Dr. Wakefield for attending the meeting. Dr. Wakefield thanked the committee for their work and said that they appreciate the thoughtfulness that they bring. She noted that she has a particular interest in rural and welcomes their advice and will do everything that she can to make it actionable.

Committee Business

Overview of Meeting

Governor Beasley noted that a lot has to be decided in two days because things have changed directions. The speakers need to be arranged not only from HHS but from stakeholders and key associations. They can provide the committee with good insight of the key points that need to be considered. He reiterated from Mary Wakefield that they must make recommendations that are actionable or they lose their scope and their ability to make an impact. The committee needs to

thread the needle and make the recommendations concrete, actionable items because their charge is to HHS and the Secretary.

Let's us keep that in mind in the next 24 hours as we make decisions on how to break into subcommittees. Please be focused on actionable items. Governor Beasley noted that he would be leaving for a meeting on Haiti relief and significant restructuring and rebuilding issues. He will also be going to Pakistan and Saudi Arabia. He thanked the committee for their support. He stated that Larry Otis does a great job of filling in and also Tom Morris for keeping things going. He noted that when talking about the 2010 report that he wanted to have comments from Larry Otis on that.

Larry Otis stated that this week the committee will be deciding on what topics to be working on. Dr. Wakefield set the tone of "no more of the same". He mentioned doing a whitepaper or a "now" report that can be given to HRSA while all of the change is taking place instead of waiting a year to produce a report. Mr. Otis said that he wants to talk about what is practical, what will work, and what needs to be done. The report needs to be solid and there need to be long term and short term considerations. Short term so that we can take advantage of the momentum and funds that may be available. He asked the committee to keep their mind open and that they may come up with a different type of report than they have done in the past.

April Bender said she thought they had decided to make a radical change by putting the recommendations up front. They could look further into the document for further evidence. She noted that 2-3 pages should be max and she thought they were making progress.

Larry Otis said yes, the shorter it can be the better it is for the person who is making the decision.

John Rockwood said he was wondering how they may be most effective and if there is a way to close the loop. The topics that have been reviewed by the committee in the past ten years are still being discussed. If there is someone in HRSA or HHS who is studying a topic that the committee has already looked at, they may be able to react instead of inventing a solution.

Larry Otis said that they could query those areas of interest and maybe recommend research to support those ideas.

John Rockwood said if there are topics they have discussed before, such as obesity and child health in rural settings, they could us that information as input into a policy that is being developed or an issue being worked on. He noted that if they could get a draft of the policy it would help to find a way to close the loop.

Tom Morris said that they do not have to do an exhaustive annual report in the future. They could do 3 or 4 smaller products. They could revisit a topic to tie to a current event or if there is something that will emerge in the coming year. He said there would be 2 hours during tomorrow's meeting to come to consensus on topics. Maybe it could be more like 1 or 2 page policy briefs. There are many options it is just a matter of getting a consensus and everyone being comfortable about where they are going.

Governor Beasley gave the example of 4 or 5 years ago they looked at the topic of obesity and now it is a priority of the first lady. He noted that the committee could pull that information off the shelf and re-evaluate it.

Tom Morris said that in the Letter to the Secretary they could note that they reported on obesity in general in previous reports and they will send a brief that is updated with some current thoughts.

Robert Pugh responded that he was not familiar with the relationship with the Secretary or Dr. Wakefield but it might be beneficial to meet with their staff and discuss things with them. He commented on the issue on resources that Clint mentioned. He said that all of the recommendations required resources, not just money but some human capital. He asked if the staff had thought about costing out the recommendations before they are submitted. He noted that it may be a good idea to do that. A lot of the recommendations include evaluating, instructing and review. That does not take additional appropriations but it does take additional time and effort. It may be good for the committee to be involved in conversations with the staff to the Secretary.

Tom Morris said that he has more interaction with Dr. Wakefield than the Secretary. He noted that Dr. Wakefield is very knowledgeable about what is happening in the Office of the Secretary and she is the most direct link that they have to the Office of the Secretary.

Maggie Tinsman said that she likes the idea about an action agenda. She said usually there are 3 topics or subcommittees. She thinks there should be one main recommendation from each subcommittee. There can be other recommendations in the appendix. The main 3 should be on one page to go to the Secretary, HRS and the Congress and whoever else will receive it. She noted that people do not read things. She did note that it is a wonderful piece of literature with graphs but people making the decisions need two sentences about one recommendation. She also noted that the recommendations need to be very specific. There can be background materials and statistics that they can refer to but it does not need to be in the recommendations.

April Bender said actionable also tells the Secretary what the expected result will be of the recommendation.

Tom Hoyer said in the Home and Community Based chapter there are very specific recommendations. There is some good information in the report and they could put the recommendations in the front at this point. He said if the committee met every week that it would not be often enough to review the ongoing work of the department. It is impossible to keep up with what is going on in the department. Think about what it would be like if we wanted to consult Mary Wakefield on her thoughts. We would have to be here 24 hours a day. I am offering the point.

Governor Beasley said when he went into the communities that the leaders in the healthcare and different associations would give him regulations that needed to be changed. They would give very general information. He told them they needed to know the specific regulation and the specific problem so they could know exactly where they are missing the boat. He said it was difficult to get them to tell him the exact problem.

Tom Hoyer said that Tom Scully, in CMS, started doing town hall meetings and they had conference calls with provider groups every month or so. It seemed to work well.

Karen Perdue said it seems that there are two issues on the table, “what” and “how”. There is was a plan for “what” but now we do not because of the unexpected changes in congress. She said she thought they had made progress on the “how”. She would like to get feedback on the actual recommendations in the report. She stated in the Primary Care Workforce part of the report it is quite specific. It may be too long but there are specific recommendations that can be moved up. Then they can continue shortening and being more specific. The “what” is challenging. She noted she likes the “value added”. If they see an agenda that is moving, can they add value to it? It is better than trying to figure out what might be coming down the road.

Graham Adams thought they needed to keep in mind what Mary Wakefield said about this committee being a role model for the rest of the committees in HHS and throughout HRSA. Part of the success has been the clarity and depth in which the committee has brought forward on topics. The report needs to be concise but not so concise so that someone who moves a bit slower than Dr. Wakefield will not have enough detail or background to move forward in a meaningful way.

Tom Hoyer stated that part of what Mary Wakefield wanted can be achieved by arranging pages.

David Hartley said there is a dilemma between brevity and having an evidence base about what they are saying. There should be a series or hierarchy of products. Somewhere there is a huge product that no one wants to read but if anyone wants to see the evidence for what we are claiming is true, we can point to it. If we want to come up with one page reports, it is a great idea as long is there is a trail that leads to the evidence. He said that it seems they are being oversimplified when they say, “just tell me what you want” in the recommendations. Some of the people who tell you what they want are advocating for something that is going to line their pockets. We have put the regulations in for very good reasons. Very often you will find that there is evidence on why to make changes and also evidence on why not to make changes. A dilemma for the committee is when there is conflicting evidence. Do we just step aside and say we better not take on an issue, or hash out the difference and make recommendations, or do we say that we think that HRSA or DHS needs to study this a bit more.

Larry Otis said that it may give them an opportunity to say let’s have a dialogue on this. We could have dialogue with the people who make the decisions and state it verbally.

Tom Hoyer stated that one of the challenges of the committee is the charter says they are an advocate for rural interests. An advocate asks for everything he can get and a little more. The committee has not been a prudent arbiter of what rural America might need given the economic conditions. People in rural areas are saying they need more assistance with fewer strings. How do you do what your charter tells you to do, which is make the case for the people you represent, as opposed to making some civic case for future good government. He said that he did not know how to do it in terms of the charter.

2010 Report to the Secretary

Tom Morris stated that the recommendations had been moved forward and the report has a different format then the past years and he thought it was a step in the right direction. There are still edits to be made to the report. As far as content, it should not look much different then what the committee has seen in the individual chapters.

Governor Beasley said that he did not think it would be appropriate to vote because the committee had not seen the final report a week in advance. He asked the members to read it for the next few nights. Friday morning, if there is a consensus and enough members feel that they need more time then they can postpone the vote until June or have a teleconference call in the next few months. There is a pressure to get it completed but it needs to be done right.

Tom Morris recommended that reopening this report and try to get to Dr. Wakefield’s points is not the right thing to do. He said that he thought her points where for the format for 2011. Once

you are comfortable with the information, let's move forward. He said that they do not have the resources to make too many changes to this report.

Governor Beasley said that his Letter to the Secretary can have an executive summary that pulls all of the recommendations to the front.

Tom Hoyer said that it is a good idea and if the report is approved and it is put in the clearance process by the end of the day, it may get to the Secretary by August. He said that if they want to move forward then they need to get the report out so they can begin on the next one.

Governor Beasley said that there would still need to be a vote by the committee Friday or soon after. That concludes the discussion on the 2010 report.

Tom Morris introduced Deborah DeMasse-Snell and she summarized travel and reimbursement information.

Health Care Association Perspective

Joanna Hiatt, Senior Associate Director for Policy, American Hospital Association

Joanna Hiatt began by stating that the association has a lot of priorities involved with rural health and rural hospitals. The one that is by far in the forefront is health information technology. She noted that about a year ago congress signed the American Recovery and Reinvestment Act. It had a large amount of money for hospitals and health providers for implementing electronic health records. CMS issued their proposed rule on how hospitals and physicians would become meaningful users so they qualify to receive incentive payments. CMS proposed a staged approach to becoming a meaningful user and over time providers have to meet increasing definitions and have increasing components implemented. Stage 1 applies in 2011 and 2012 and focuses on electronically capturing health information in a coded format so it can be used to track clinical decisions. Having the information in a coded format is also for communicating the health information for care coordination purposes. As part of Stage 1 there were 21 requirements that hospitals have to meet to be meaningful users and they have to have all to qualify. She noted they thought that CMS was asking for too much too soon for hospitals. If the rules are finalized there will be hospitals that are extremely advanced in HIT but will not quality in 2011 or 2012 as meaningful users. They feel that CMS's approach should be changed to be more flexible and have a more gradual transition. For small and rural hospitals they do not think it is tenable. It is small hospitals that are behind the curve, not just rural hospitals because they have 3 already. They will have further to go to get the 23 or whatever the requirement ends up to be.

The rule does propose a limited transition mechanism. If they qualify first to be a meaningful user in 2013, they will still be able to do so by meeting the Stage 1 requirements. If they qualify by 2015 they will still be required to have the full EHR implemented so it only helps for one or two years. If it is not fully implemented in 2015 there will be penalties under the Medicare program.

The American Hospital Association has been working to develop an alternative proposal that would still work to get them to full electronic health records. It is more flexible and gradual. Instead of implementing 23 objectives, hospitals, for the first stage, would have to implement 25 percent of the requirements. The hospitals can choose the requirements that are most important to them and implement those. There may a few that are mandatory requirements. Under the American Hospital Association proposal the time is extended to 2017.

Rural and small hospitals should have an exception. The transition would be more gradual so that they could get more money upfront to help them. At the first stage they would need 15 percent implemented instead of 25. They would end up in the same time frame but the requirements would be lower in the beginning to give them time to get the funding.

Implementing an electronic health records is extremely expensive. It takes years and years and costs in the millions of dollars. There are huge upfront capital expenditures. In Medicare and for the most part under the Medicaid program you do not get the incentive payments until you have expended the dollars and gotten the EHR. The Medicaid program has more flexibility than Medicare. The payment for HIT is the aggregate payment that you would get over 4 years. States can pay the 4 year amount between 4-6 years. In any one year the state can not pay more than 50 percent and any two years then can not pay more than 90 percent. It would be beneficial for CMS to instruct states to pay the maximum amount since the Federal Government is providing a 100 percent match to states for the HIT.

The final point that she spoke about is eligibility for the Medicaid program. For Medicare Subsection D, Critical Access Hospitals are eligible. The statute for Medicaid states that Acute Care Hospitals are eligible. CMS has proposed that Short Term Acute Care Hospitals are eligible but they did not include Critical Access Hospitals as short term hospitals. She does not understand why. The Critical Access Hospitals need these incentives because in Medicaid there are no associated penalties. Critical Access Hospitals are the smallest of the small and can use all of the capital funds available because they will have the hardest time getting loans from the bank.

Alan Morgan, Chief Executive Officer, National Rural Health Association

Alan Morgan started by saying that it is good to be at the meeting to talk about rural health issues. He was glad that he could hear Dr. Wakefield speak about keeping recommendations focused. He said that he has all of the past reports from the committee in his office. He stated that the recommendations on the website were clear and concise and very helpful.

Tom Hoyer's remarks to Dr. Wakefield were what he talked about first. One of the easy, low cost recommendations in a past report was that the Administration collaborates across agency lines on behalf rural health. He said that he knows it is occurring under Tom's leadership in the Office of Rural Health Policy. They have been working with the Veteran's Administration, CMS and most recently with USDA. He noted that it needs to happen at Dr. Wakefield's level and he knows it is one of the key goals of the Administration. Mr. Morgan said that rural health is not just health but multiple issues that come together. He thinks that moving the Office of Advancement of Telemedicine back into ORHP is a good move. He would like for the advisory committee to revisit what regulatory legislative policy changes could be made to improve the distribution of telemedicine in rural America.

Mr. Morgan said that Joanne did a great job of outlying the concerns of "meaningful use". The committee has a strong history of communication in back recommendations that there has to be rural appropriate measures. That is important in HIT and its implementation into rural communities.

Mr. Morgan talked about policy issues that are under consideration at the National Rural Health Association. At the May conference they looked at policies concerning food and nutrition, telemedicine and prevention of chronic disease. They looked again at rural hospitals and what would be appropriate through policies for rural hospitals. He spoke about the hospitals that are too large to be critical access but too small to keep up their numbers up financially. PPS hospitals are unable to convert to the Critical Access Hospital Program because of the legislative changes made under the Medicare Modernization Act. MMA removed the Governors' ability to designate hospitals as necessary provider hospitals. Under these economic situations there are hospitals that have no recourse to adjust how they are paid from Medicare. He asked that the committee consider recommending to the Secretary to work with congress on reinstatement of the necessary provider provision.

There were two final things that he wanted the committee to consider. In the reauthorization of the Medicare Rural Hospital Flexibility Program, there is a reemphasis for the program to focus on information technology and the promotion of quality improvement. In conjunction with the Small Hospital Improvement Program, these two programs can work together on the issue of

quality improvement. This will assist the Critical Access Hospitals to meet the goal of having high quality healthcare. He spoke about how many different types of providers there are in rural America. He said that the ongoing challenge is to insure access to care without having service overlap. There has been progress made under the stimulus legislation. They continue to have a difficult time with new providers locating in communities where there are existing providers. It is an ongoing policy issue. He hopes that the advisory committee can take on this issue going forward.

John Rockwood said that typically the applications build on one another. We do not want to force a hospital to implement applications just to get to a mark at the end of the year. He said that sequencing this over a period of time and specifying percentages of a system may not make sense.

In rural settings there are small hospitals and small groups of physicians. Is it not very inefficient to focus on small hospitals without having a nexus of providers who can service multiple entities? It is inefficient for hospitals to have their own IT staff or a 2 or 3 physician group has its own IT staff. Why is there not an emphasis on trying to create an entity that would service a variety of different providers, but that entity would get the funding and not the individual hospitals?

Graham Adams said that there are challenges of balancing rural constituents. If the committee could help reduce the barriers and increase incentives for different providers to work collectively and coordinate at the local level, there would be a visible change in the way health services are provided in rural communities.

Tom Hoyer stated that he would like to make sure that he understands the problem of overlap. It seems that it is a problem when competing providers dilute the patient population so that none of them is making enough money. He feels the solution would be improved health planning. That does not sound friendly to the notion of competition but does sound friendly to the notion of health planning.

Alan Morgan stated that in NRHA, more than 90% of critical access hospitals are members, 90% of rural health clinics are members and close to 90% of the rural community health centers are members. If there was a way to overlap the different provider types and see where the gaps exist, we would be better able to target federal dollars. We want to be able to promote healthcare cut access where we currently do not have it.

Tom Morris said that if you are a Community Health Center and a hospital opens a Rural Health Clinic, there is nothing in the regulation that requires anyone to acknowledge who is already in the area before they receive money.

Esther Morales, Special Assistant to the Deputy Assistant Secretary and Inter-Departmental Liaison for Early Childhood Development, Administration for Children and Families

Esther Morales started by thanking the committee and apologizing that Joan Lombardi could not attend. She began by giving background about the early childhood work that they are doing with the Administration of Children and Families at HHS and the context of that within the Administration's agenda. She said that there has been a new emphasis on early childhood under the new Administration. Joan Lombardi is the Deputy Assistant Secretary and Interdepartmental Liaison for Early Childhood Learning and Development at ACF. They work closely with the Department of Education on the President's 0-5 Agenda. They are also working with other agencies to ensure that the interests of young children are considered in discussions on health care, maternal and child health and mental health. ACF is moving forward with an Early Learning and Development Interdepartmental Initiative bringing together federal employees from HHS and the Department of Education, Labor and Agriculture. They are participating in study groups to improve the quality and coordination of early childhood services across the federal government. Jacqueline Jones, Senior Advisor to Secretary Duncan, on early childhood at the Department of Education, and Joan Lombardi have been working together to move forward the Early Childhood Agenda. The study groups are made up of federal employees from the Department of Education, ACF and HHS. They will be looking at early learning standards, curriculum assessment, program standards including: licensing, quality rating and improvement systems. They will also be examining early childhood workforce and professional development, data systems, health promotion and parent and family engagement. These areas will touch childcare policy in the states and Head Start policy and have an impact on rural early childhood development.

The 2011 budget summary shows 1 billion dollars in new Head Start money and 1.6 billion in childcare. These are historic increases. She noted that many of the efforts, such as the collaboration with the Department of Education, and the historic budget increases are driven by the Administration's 0-5 agenda. It includes a proposal for an Early Learning Challenge Fund Grant Program. The Early Learning Challenge Fund was included in the President's fiscal year 2011 budget in the Department of Education that proposed a 9.3 billion dollar investment over ten years. The program would be competitive grants and states would compete to establish model systems of early learning that set a quality standard for all early childhood.

Whether or not the Early Learning Challenge Fund Legislation passes, ACF is going to do everything possible to improve services and target resources for the youngest children. Also, they are finding ways to find coordination across departments.

The Administration of Children and Families put forth an idea for a place based initiative that focuses resources on caring communities. Communities that want to create innovations for children 0-8. There are four aspects of the initiative. They are identifying cities that are planning across urban departments for children under five. They would like to bring together eight to ten cities. There is also a plan for a rural institute. They want to identify communities that are doing cross departmental work for children. She noted that if resources were more targeted and concentrated, they could bring necessary services to communities.

Ms. Morales said that Promised Neighborhoods is the Department of Education's Place Based Initiative. The 2011 budget has 210 million and the committee should think about how the rural communities can link with the initiative. The program is a component of the Office of Innovation and Improvement at the Department of Education. The Promised Neighborhood's Initiative would support a second cohort of competitive one year planning grants in 2010. The first cohort in 2011 would be five year implementation grants. The programs are to combat poverty and improve education and life outcomes.

Sharon Hansen emphasized that it is wonderful that The Department of Health and Human Services is reaching out to The Department of Education. It is very important in rural areas. She has an interest in knowing about states that are not investing state funding in pre-education to young children. What type of new incentives will there be to have those states embrace receiving the federal funding that require a state match.

Esther Morales responded that collaboration is more than just getting together and seeing what the other departments programs are doing. The Department of Education consolidated some small programs to more heavily concentrate resources in fewer areas. They are looking at programs and the nature of the program and creating solutions. They have more flexibility and work more closely together to fill in the holes.

Ms. Hansen said that states with an infrastructure are able to take advantage of the grants. States like North Dakota that have no infrastructure are not even looking at the grants. Is there anything for states that have no infrastructure at all? With the Department of Education participating, right now the only player for early childhood is Head Start. Some of the schools are interested in providing pre-k programs and are charging parents tuition. They are doing it in a way that does not embrace the family concept and outside of Head Start. Ms. Hansen said

she is happy to hear they are talking at the federal level and hope that some of the practices being suggested will come down to the states as best practices.

Clint MacKinney said when it was mentioned that the program concept should continue past 5 even to the age of 8, it made him wonder about the role of school nursing. Mr. MacKinney asked what the role of school nursing may be.

Esther Morales responded that school nursing and resources that are available to kids for health needs from 0-8 is something that is on the minds of the leadership. Approximately forty percent of the Early Head Start Program is home visiting. Part of the Head Start's mandate is to provide certain health services. There are other initiatives happening at HHS that look at the intersection between schools and health. As the links between pregnant mothers, private childcare, state childcare systems and Head Start begin to work together with Pre-K programs, schools and communities that want to pull their resources around health will include school nurses. Head Start programs that are located in schools work closely with school nurses. At the rural institute they will be looking closely at communities that are working across the resources that they have to better serve the entire community.

Maggie Tinsman said that 12 years ago in Iowa they initiated early childhood education that combined resources of education, health and human services and brought it to the local level for all children to be ready to learn by the age of 5. There was a collaboration at the local level as well. There was funding at the state level but also used TANF funding from DHS because part of it is not just education. It is health first when a baby is born, early childhood care and education. Local areas did not get funds unless they had collaborations with Head Start, their school districts, health departments as well as human services. She noted that she is excited to hear that the federal government sees this is an important initiative. She questioned how they can help the states that have initiated 0-5 year old programs. Maggie Tinsman noted that she was talking about financial assistance.

Robert Pugh asked if you were going to identify the communities that you will be working with for the institute in March.

Esther Morales said that they have not identified the communities. The rural institute is a kick off to the whole initiative and it is the first step in surfacing the communities or states that are doing innovative things. They are looking to produce the publication and have a better sense of what the communities are.

Larry Otis said that he would encourage a longitudinal data system. He said there were 1,300 or more programs for children in his state and they have no data on them. He thinks there should

be a state system to collect educational data, family data and health data.
If there are statistics early on about children they can be followed throughout the school years.

Esther Morales states that they are looking at data systems for young children and there is a question of how to integrate it into the 0-12 grade system. She noted that there will be opportunities to discuss it.

Sharon Hansen said that there state had applied for a federal grant so that they can target children the moment they enter a system. The children would be assigned a number so that they can find out how services or adverse situations impacted a child before they enter school.

Committee Discussion

Takeaway from Day 1

Larry Otis stated that the committee could now discuss topics and takeaways from day 1 of the meeting.

Robert Pugh started by sharing that the issue of actionable items is important and can be challenging. Meaningful use and incentive payments in EHR, and looking at something about the use of EHR and telehealth in rural communities should be a priority issue for a subcommittee.

Tom Morris added that when looking at meaningful us, the public comments were around March 15 so it can not wait until next year. It is an issue that should be raised in a different vehicle than in the report.

Todd Linden stated that this is an extremely important issue, especially to rural providers and time is of the essence. He noted that they may want to have a representative group meet with the Secretary so that we can put emphasis on it.

Maggie Tinsman said that Dr. Wakefield noted that there is a need to move forward and not do more of the same. She suggested that there be a particular rural, elderly population in a small area where people are Medicare and Medicaid eligible. Review how these can be combined differently and maybe even called something different. We need to look at an innovative program for frail elderly rural in small enough populations to see if some savings can be obtained by bringing together Medicare and Medicaid.

Larry Otis responded by saying that Mississippi has dealt with that. They recertified people every year and eliminated dual eligibility.

Clint MacKinney said that he thought that they should discuss how to assess federal money going to areas where there is already federal money or private enterprise. We should look at whether or not it is actually supporting or hurting competition.

Tom Hoyer stated that the thing about competition is that it envisions winners and losers and in rural America it can not afford to have losers because the providers are fragile. That is an argument for broader control but that is not compatible with flexibility. He noted that it is a difficult subject but personally he thinks that some type of health planning is something that should be discussed.

Tom Morris responded that tying future funding for either expansion of health centers to looking at if there is an existing “safety net” provider. You could recommend changes to the regulatory structure that would verify that. CAH’s could have to tie the 101% to collaborations. In the FLEX program that provides grants to the states, one of the approved uses of the funds is looking at collaborations between FQHCs and CAHs. There are small incremental ways.

David Hartley said that regions or states can create a program with a waiver that would allow them to blend the funds from all of the different programs. An incentive to do this would be the incentive that is in Type 2 billing for critical access hospitals. If you blend everything, you get a 15% boost in what they get back since it is a pilot program.

April Bender stated that along with the waivers they could be looking at silos and natural silos that are created out of legislation and policy. The committee could examine where things are naturally occurring and it may be a way to look at reducing some of the funding. One of the best ways is to study what is already created and keeping us from the interdependence.

Larry Otis said that there were about 261 programs that fund early childhood and there should be opportunities to combine some of those.

April Bender said that they were trying to study partnerships in a couple of rural areas. If a grant comes in, 2 or 3 agencies get together and talk about it and who may have the best expertise. Independence is if one agency, hospital or client goes, there is a huge loss. They help keep each other funded because if one “falls out” it is a significant loss. It is a theory but there are places where it is being practiced.

John Rockwood said that Mary Wakefield talked about what to do about performance based pay. How do we pay to keep people healthy? How to measure that in a rural setting? It may be helpful to focus on the current problems with the current reimbursement systems. A way to change behavior is to change the payment system. We need to align the payment systems to

encourage local providers not to duplicate services. The committee can point out the problems with the current system and solve those problems so there is a solid base to build on. That should precede the reimbursement system being changed in rural areas.

Clint MacKinney said that if healthcare reform would have moved forward, the committee would be assessing bundled payments to Accountable Care Organizations. We may want to still discuss that issue.

Todd Linden said that it is in the current report. There should be some piloting to learn from before moving forward. He noted that in his community, 80% of physicians are in private practice. It is difficult to even know where to start.

Tom Morris said that he brought up the issue with Mark Miller, the staff director of the Medicare Program Advisory Commission. He brought up the issue and his response was that it is not a rural issue that he is hearing the same thing from the urban. He said that he needs to know what the issues are that are distinctly different for rural that would not be true for small urban. There is an opportunity to think about this and be very specific on bundled payments and ACO's and raise the issues.
Tom Morris stated that they need to use the report for specific issues and use the white paper for the broader issues.

Tom Hoyer said that it would be useful for ORHP to have someone look back at the previous reports and find information that has been discussed previously that is relevant at this time.

April Bender brought up TANF and asked if there was something that had surfaced.

Tom Morris responded that TANF had been brought forward as a discussion point. He noted that it is great to put people into workforce training but if there are no jobs in that community then you are training them for something that does not exist.

April Bender said that is true but that many of the states have to put people into training because there are no jobs.

Larry Otis said that his area gives people regional sector training. For example they need two thousand welders in Mississippi and can only produce one hundred and fifty every six months. He said it was due to a lack of training facilities.

Tom Morris stated that they need to agree on 3 topics for the report. There needs to be specific instructions on what the white paper should be and what should be in the report.

There were no public comments. Larry Otis closed the meeting.

Thursday, February 18, 2010

The meeting was convened by The Honorable Larry Otis, Vice Chair of the Committee.

Issues Facing the Rural Elderly

Robert Blancato, Matz, Blancato & Associates, Inc.

Robert Blancato began by saying that the committee has an enviable record of impacting policies for people in rural America and he was honored to be at the meeting. He noted that he would be discussing existing and new federal programs related to the aging in rural communities. He focused on the 2010 human services topic and Home and Community Based Care Options for seniors. There are a rising number of elderly people and there is a need to contain costs and provide better choices of healthcare for seniors. Challenges in rural America are the larger number of older people and the higher rate of chronic disease among the elderly. A third more of rural people are covered by public programs like Medicaid and there are a higher number of dual eligible's than in metropolitan areas.

The ARRA bill had pertinent provisions that should benefit rural seniors. There was an 87 billion dollar increase in Medicaid FMAP. There were new investments in Health Information Technology, prevention and wellness and a 100 million dollar increase in the OAA nutrition funds. There were also valuable infrastructure investments to improve infrastructure investments to provide jobs and improve transportation. In addition there was an initial 2.5 billion dollar investment for rural broadband loans and grants. The question for the committee is what the results are. Has an assessment been made on ARRA. If so, how do we continue to programs that have produced the intended results and to realize that there will not be an ARRA II. There will be pieces of it such as a jobs bill and an individual appropriations bill. There are Administration initiatives that will come forward in areas such as prevention and wellness.

The President's budget includes a 6 month extension of the FMAP increase under Medicaid and 100 million dollars in new investments in OAA. If these are adopted they will be in Home and Community Based Care. The unknown factor related to Home and Community Based Care is the fate of Health Care Reform. A number of important features in the bills are a possible Center for Innovation, Accountable Care Organizations, bundling payment initiatives, a Coordinated Health Care Office at CMS, medical home/health home proposals, workforce investments and community transformation grants from the CDC. It also included a 5 year extension of the Aging and Disability Resource Center and a 10 year extension of Money Follows the Person.

If the Health Care Reform occurs then the focus is on implementation of many different provisions. If health care reform does not happen, what will keep community based options for seniors moving forward. It will need to come from individual bills. There may be amendments to other bills that address the same issues. The work that is done by the bi-partisan commission that the President is appointing will address the future of entitlements including Medicare and Medicaid. The reauthorization of the Older Americans Act, The Workforce Investment Act and Transportation Equity Act could also play a role.

The Older Americans Act Reauthorization is pertinent to home and community based services for older individuals. The reauthorization process is underway. The first of the Administration on Aging sponsored forums was held in Boston and today their first official event is going on in Dallas. The reauthorizations are opportunities to improve, modernize and weed out underperforming programs in an existing law. There should be a stronger rural, elderly agenda in the 2011 reauthorization. There needs to be an assessment of the targeting language from 2006.

Mr. Blancato noted that there needs to be an emphasis on transportation in the Older American's Act and the Transportation Reauthorization Bill. Transportation gives the elderly a way to access the essentials that are needed for a good quality of life. OAA needs to expand support for rural transportation and invest in new models for the future.

Elder abuse is a huge issue that needs to be addressed. OAA must do its part to fight against elder abuse and neglect. The only program is Title VII, but funding has been stagnant since 1992. This act is crucial in working to fund grants for statewide elder justice systems.

Project 2020 initiative is an exciting possibility within OAA 2011. This would include directing funding into the aging network from the Medicare trust funds to expand three types of services. This includes person-centered information, evidence-based disease prevention and nursing home diversion.

A more aggressive economic development policy for rural America is important. Federal funds like ARRA and future programs should connect to local economic development offices or related agencies in rural America to get the best us of funds.

He stated that standardizing the definition of rural to be more universally acceptable for program designation is something else that needs to be addressed. He also said that there needs to be an end to fragmentation of rural programs. He stated that in 2003 there were 225 programs just in HHS that were serving rural communities but had different criteria.

Robert Blancato ended by saying that the committee work is vital to the sustainability and advancement of advocacy relating to seniors. Looking at the year 2011, the first wave of baby boomers turn 65 and that hugely impacts Medicare. The largest number of boomers turns 50 in 2011. He also noted that the retirement age goes to 67. There are a lot of things happening around aging in 2011.

Q & A

Maggie Tinsman said that in Iowa, they have the largest number of 100 year olds per capita in the nation. She said that she was interested in bundling payments in Medicaid and would like for Mr. Blancato to explain what he meant by it.

Mr. Blancato said that that it is different forms of payments that come through hospitals and health care facilities and are bundling together in a coordinated way to ensure that everyone knew where the funding sources where and what their outcome would be. People have looked at it as a way to improve the value of health care dollars going forward. He said that he could provide her with more direct information about it.

Maggie Tinsman said that one of the recommendations that she is making to the Secretary is to look at bundling Medicaid and Medicare payment for the dual eligibles in the poor, rural area.

Mr. Blancato said that if there is no health care reform, there are a number of things that can be done administratively through the initiative that the department can take. There are a lot of well thought out ideas in the health care reform that would be a shame to have to wait for a large, legislative vehicle to come forward to get them passed. He believes that they will be active in dual eligibles, bundling, and CMS innovations.

Administration on Aging Perspective

Robert Hornyak, Aging Services Program Specialist

Robert Hornyak stated that there are 3 key areas with the Administration on Aging. They are culture change, evaluation and performance and reauthorization of the Older American's Act.

Culture change is a term often used in nursing facilities. It is also looked at in terms of services, programs and opportunities to perform better for older adults and caregivers. Since 1965 the Older American's Act has been a highly regarded statute. With 56 state units on aging, 629 area agencies on aging and approximately 20,000 services providers and 500,000 volunteers across the country. The Administration on Aging through the Older American's Act serves approximately 11 million individuals a year. 700,000 are family caregivers and there are an increasing number of individuals with severe disabilities. About 350,000 of the home delivered

meal recipients have three ADL activities of daily living limitations or more which is equivalent to a nursing facility level of care in many states. One of the ways to think of the Older American's Act is that it is comprised of two issues which are health and independence. Health is through the nutrition program and health promotion activities. Everything else is about independence. That means staying in your own home and being able to go to the doctor through transportation. It includes the chronic disease self management programs. All of those issue to be able to stay in your won homes and live healthy.

When Cathy Greenly became Assistant Secretary on Aging, she wanted to enhance and promote the core services offered through the Administration on Aging. The Administration on Aging is going through reorganization and the name will change from Core Programs to Home and Community Based Services. The Core Programs are Title III of the Older Americans Act B and are supportive services that include: homemaker, chores services, transportation, and information assistance. The Title III C Programs are congregant and home delivered meal program, nutrition counseling and education. Title III D is health promotion and disease prevention activities and Title III E is the National Family Caregivers Support Program. Enhancement of these services means better performance but also more money. Many states have had to reduce state and local funding on programs across the board and in some cases for services for older adults. The announcement from Vice President Biden about a middle class caregiver initiative is exciting. The proposed budget for it is 102.5 million dollars to increase services for III B Supportive Services, III E Caregiver Services and for the Life Span Respite Care Program. This will help increase the number of older adults that receive services and also help to support our family caregivers.

There are people taking care of their own children and their parents. Those generations who are under stress, need the assistance through the services available through the National Family Caregivers Support Program. There are 5 service categories in the program. One is information. The number one request from family caregivers is information. The next service is assistance which includes getting connected to services. Counseling, training and support groups is needed by caregivers. Many caregivers feel isolated and they need support. It is difficult for a caregiver to leave their home and do tasks. A mobile adult day service where professionals would go to a rural area and families who need respite and are continually providing care will have time for other activities. Conference calling is a great form of support. Caregivers can call a number and share their experiences, learn from each other and be part of a network. 75%-80% of long term care services and supports in the country are done by family, friends, church members and neighbors. The paid professional care is offered but a small slice of what it takes to keep older adults independent and in their homes. Those caregivers need to be supported in every way possible. Respite care is an important service component. Just to be able to take a

break from the responsibilities and care giving. Respite care is the number one expenditure for caregiving. Training is a crucial component. Most people really do not understand what it takes to provide long term services. It may include transfers from chairs, feeding and many other things so that an adult can stay in their home. It requires training. It includes how to lift a person without injuring yourself. The final category is supplemental services. Supplemental services include services that are undefined. It is left up to the states and area agencies.

The Life Span Respite Care Act was passed in 2006 and funded in 2009. The funding was through Public Health Service Act. 2.5 million dollars went to The Administration on Aging for lifespan respite care. State units on aging have a mission to serve older adults and their caregivers and also provide services to other populations as well. The opportunity is to pull together coalitions for many populations and provide respite for all ages. This could include parents of young children, those taking care of young children and older adults or an older adult taking care of a spouse. There are adults that are 75 and care giving for their 95 year old parents. We need to connect the dollars and services so that people can receive the respite care that they need.

This year community innovations for aging in place were funded 5 million dollars. The first task was for the experts in the field were to discuss and debate the term aging in place. What does it mean to age in place? There were competitive grant put into place in communities to learn what it means to age in place. State agencies were not eligible for the grants. The money went to communities. A tribal consortium in Glaucoma, Alaska received a grant to show what it means to age in place. They are culturally different and environmentally different. There was a grant given to learn what it takes to age in place in Albuquerque, New Mexico. We are looking at rural areas to learn what it means to age in place.

On the health side they are advancing evidence based interventions. There are numerous best practices that communities use and AoA uses. There is emphasis on evidence based interventions such as chronic disease self management programs. The criteria for evidenced based is that the practices have gone through control groups to determine that it makes a difference in people’s lives. It can be extremely helpful in reducing re-hospitalizations.

Care transitions look at a team approach that helps individuals when they return home from the hospital so that their medications, chronic disease and acute conditions can be managed to reduce readmissions and unnecessary readmissions.

There were two last points that Mr. Hornyak spoke about culture change. One is on workforce. There are not enough workforces to go around. What policies can the Administration on Aging adopt that gives them the ability to work with partners? He noted that 75% of veterans are over

the age of 65. An interest at the Department of Veteran Affairs is to have the home and community based network that the Administration on Aging has in place. There are younger veterans that are returning with severe disabilities and want to live at home. These veterans, like everyone else, want to be in charge of their lives. Administration on Aging is serving veterans of all ages in 7 states. By July 2011, the Veteran Association's goal is to have 109, 362 veterans in Home and Community Base Services. He noted that they would like to help the Veteran's Association to achieve that goal. He spoke about a sergeant in the US Army who was in Afghanistan and was injured. He and his wife live in rural North Carolina. He is 24 years old. He is a basically a healthy person but has a significant head injury. He still goes on a 10 mile run but can not find his way back. As respite care his family would like someone to run with him. At the home health agency there are not many people that can go 10 run miles. Is that what we think of respite care? How can we meet his needs and offer veteran's directed services. An example is he can receive money to hire a friend or neighbor to run with him. It does not have to be defined by a service category.

The Agency on Aging has to provide performance data and it speaks well for the areas that they are required to measure. One is in targeting. They serve a higher proportion of elders living in rural areas, are low income and in a minority status. There are several evaluations that they having during the year and one are nutrition. Nutrition programs are the largest expenditure of the Older American's Act. Is it better to serve 5 frozen meals on Monday or do they need a hot meal everyday. There is a large scale evaluation happening.

There is an evaluation of the Title III E Family Caregiver Program in terms of practices that are most effective. The assessment is to identify the needs of caregivers and care recipients. There is a comparative effectiveness research in terms of care giving. It includes a research review. There are tools that can help caregivers understand and reduce the emotional stress and toll that care giving takes on them. He noted that they do not know much of the physical aspects of care giving and how to relieve that stress.

Aging and Disability Resource Centers is the final thing in terms of evaluation that Mr. Hornyak spoke about. 54 states have received grants for these centers and he noted that they hope this would continue to expand. The ADRC is their point of access for Home and Community Based Services for options and counseling and for people to find out how to get the things that they need. There are physical locations and virtual locations.

The Older Americans Act was last reauthorized in 2006. In 2011 Congress will consider reauthorization and amendments to the Older Americans Act. The Administration on Aging is looking for input and the committee could have significant impact on the considerations and recommendations toward the Older American's Act.

There are three listening forums being conducted by Administration on Aging. They are looking at soliciting input and there will be panels to provide commentary around wellness, workforce and capacity to provide the services. States and communities are having local reauthorization events. Virginia, Nevada, Massachusetts and California are staging the meetings so that local communities, including older adults and caregivers, can have input.

Q & A

Maggie Tinsman said that in Iowa people do not believe they are seniors until they are 90 years old. She feels that the nutrition program needs to be revitalized. It is to provide food and socialization. She said that the baby boomers do not want to go to something called “nutrition site” or “Senior Center”. Is there a way to call it something different and even let them pay a little more so that they would like the idea?

Robert Hornyak said that there are many approaches. The congregant meal program works well for voucher programs especially in rural communities. It involves working with local restaurants and offering vouchers to the restaurants, that people can contribute their voluntarily contribution. It offers choice and intergenerational opportunities to seniors. It is a coupon that gives an opportunity to go and have the meal with neighbors, family, grand children. That is socialization. He appreciated her comment and said they will continue to work on that.

David Hartley referred to the cash and counsel demonstration that is going on in 15 states. I am not sure what the impact has been for rural seniors and their families. He asked if Mr. Hornyak knows what the impact of the program has been.

Mr. Hornyak said he does not have the numbers to share but that he knows that they have been able to offer people more choices and given the opportunity for people to hire family, friends and neighbors to help in very rural areas. He said that he will find out what the impact has been in specifically rural areas.

Robert Pugh asked about the Reauthorization, and if Mr. Hornyak knew which committees in the house and senate of the legislation will be assigned.

Mr. Hornyak said that he did not have that information yet but he could find it out and get back to the committee. He said that it will be posted on the website.

Letter to the Secretary

Larry Otis stated that one of the things that they would like to do is to look at the letter to the secretary.

Tom Morris said that they have taken notes during the committee meeting about things that they may want to put into the Letter to the Secretary. The support of the ACF Rural Institute may be worth including by stating that this may be a good model of how ACF reached out to ORHP. The committee will be following the progress. The two presentations have pointed out that the committee has an opportunity to weigh in on the reauthorization of the Older Americans Act and that should be mentioned in the letter. Mr. Morris said that they can pull all of the recommendations in the past five years from reports that relate to the elderly. The committee can name the ones that are tied to the Older American's Act Authorities through a letter to the Assistant Secretary for Aging. It can state that as they reauthorize the Older America's Act they can refer to these recommendations that have been made over the past 6 years and should be taken into account. Recommendations from the 2011 report would be included in the letter.

The committee should be sending a formal comment letter on the HIT meaningful use. It is worth asking ACF to staff the committee the way AoA does and mention the Secretary considering a pilot project looking at dual eligible services in isolated, rural areas. There may be more things to consider after Keith and Jocelyn speak. Larry Otis said that the committee can add to it as they hear more from the speakers and move forward.

Graham Adams asked about what April Bender had mentioned about the data not being broken out "rural specific".

April Bender said that it is an ongoing issue and it may not be appropriate to put it in the letter. She said that there should be a way to look at data that is collected that goes out from funding from the federal government. There should be able to look at in any definition.

Tom Morris said that they can say in the letter that every year HHS collects program data that needs to be cut rural and urban. The committee urges the department in the reporting on The Recovery Act to make sure that it is captured in the rural/urban perspective.

Tom Morris reminded the committee that Dr. Wakefield stated one of the priorities of the department is to be more integrated and collaborative inside the department and also with other levels. It is particularly true in rural communities. She has talked about that numerous times at her senior staff meetings. Mr. Morris said that they will talk about topics and a potential work plan for 2010. There will be a 2-3 topic report, a comment letter to CMS on the meaningful use definition, a comment letter to AoA on reauthorization points from past recommendations, and maybe a white paper on emerging issues.

Robert Pugh said that as he looks back at previous topics and recommendations, something that may need to be addressed is the growing immigrant and Hispanic population in rural areas.

In Mississippi with the poultry industry and the logging industry, the Hispanic population is growing. There should be discussions about that in the future.

Larry Otis said that they would move into discussing topics for 2011. He requested that they go around the room and tell what topic that each committee member would like to see on the report. He noted that the report will be started in June so that they will not really be working on it until the June meeting.

Committee Discussion

Recommendations for 2011 Report

Clint MacKinney recommended investigate bundled payments to ACO's

Sharon Hansen recommended a focus on young children and the President's investment in young children, 0-5 plan. Look at the need for all services to collaborate. Parent education needs to be addressed when looking at childhood obesity.

Graham Adams recommended looking at bundling payments and incentives on a local level. Access to capital in rural areas and more primary physicians to purchase AMR's is another recommendation.

Todd Linden recommended bundling payments in rural communities and how to improve the overall health and wellbeing in rural communities.

Darlene Byrd recommended bundling payments and childhood obesity. Darlene Byrd said that childhood obesity should also be addressed by looking at adverse childhood events leading to obesity. It is a broad topic.

John Rockwood recommended looking at the problems with the current system and the problems with getting providers to cooperate before changing to a new reimbursement system. We also need to consider using the ACO and bundled payment concept to examine the payment systems and the unique aspects of rural that get in the way of coordination.

Robert Pugh recommended getting telehealth services in rural America. Recommended how to reimburse for the use of telehealth and increase access to services.

Maggie Blackburn recommended looking at the reimbursement system and at looking at services for children.

David Hartley recommended looking at childhood obesity and bundled payments. He noted that overlap of federally funded programs serving the same population is something that HRSA and DHHS could be look at efficiencies.

Karen Perdue recommended looking at planning ideas. The infrastructure in rural America needs coordination.

Tom Hoyer said taking the ACO concept and using it to examine integration, cooperation and health planning issues. Childhood obesity is also a recommendation. He noted that ACO's is a broad enough topic and has a wide variety of recommendations that are related to a number of the concerns that have been expressed. It is an umbrella topic. This is also true with the topic of children. Obesity can be addressed under the recommendation of children.

April Bender said two years ago the committee made a commitment to look at workforce. She recommended childhood obesity and it is actionable within the context of the Administration.

Maggie Tinsman recommended the rural initiative of education, childcare and health from 0-8 years old. Elderly and the "Livable Community" idea that will collaborate programs and gives an alternative to nursing homes, is another recommendation.

Tom Morris stated that linking the committees work to something that is a priority for the Administration is a good idea. The committee has a unique perceptive and is able to look at issues like bundling, and the overlap issue, from an objective view point.

Larry Otis stated that everyone expressing their recommendations individually will benefit the committee in having a consensus on the issues.

Key Issues in Rural Health and Human Services

Jocelyn Richgels, Rural Policy Research Institute

Jocelyn Richgels began by listing the members of the RUPRI Rural Services Panel as follows: Mario Gutierrez, Assistant Chair; Kathleen Belanger, Stephen F. Austin University; Vaughn Clark, OK Department of Commerce; Larry Goolsby, APHSA; Jane Forrest Redfern, Ohio Department of Jobs & Families; Bruce Weber, Oregon State University.

She noted that the first project has been completed for ORHP. It is a position statement from the panel, Rethinking Rural Human Services Delivery in Challenging Times: The Case for Service Integration.

The recommendations include infrastructure and workforce capacity needs, finding framework for regional service integration, rural human services research and technology and broadband access throughout rural America.

Ms. Richgels stated that until recently social welfare policies focused on people-based investments instead of place-based investments. In August, the Whitehouse gave guidance on policies for leveraging federal dollars for a place-based network. The new initiative from the Obama Administration is directly applicable to rural is Place-Based investment. It noted that rural develop programs need to be coordinated with broader regional initiatives.

Ms. Richgels said that Place-based context is well understood in rural health services. The federal government has made an effort to increase access and availability of healthcare services for rural residents. She stated that this is not yet the case for rural human services.

The Administration's platform for placed-based policies is called the Livable Communities Concept. Social inclusion is an important component of the policy. She noted that poverty, disadvantage, food insecurity, social and human capital need to be addressed for thriving people and communities. There are five areas in the human service field that could be considered from a place- based perspective and for rural families and children to thrive. They include TANF and childcare development, the impact of substance abuse on child welfare, childhood obesity initiatives, rural human services research and data collection, and understanding regional service delivery networks.

Ms. Richgels stated the four national mandated goals for TANF which are assisting needy families so children can remain families, reducing the dependency of needy parents by providing job preparation, preventing out-of-wedlock pregnancies and encouraging the formation and maintenance of two-parent families.

Ms. Richgels talked about childcare needs in rural America. She noted that poor, rural families are more likely to be employed and have two adults in the household compared to poor families in urban areas. Almost 25% of rural female headed-households live in poverty. Also, the lack of access to childcare in rural America can be a problem for employment for families with children. She also said that the use of childcare subsidies may be lower in rural America.

The next subject that Ms. Richgels discussed is TANF and childcare funding. She said that childcare subsidies through CCDF ranked second only to cash welfare in the state reported TANF activities. She added that TANF funding is not only for families getting cash welfare and it does not count as "assistance" to families with a member of the family employed.

Ms. Richgels discussed substance abuse in rural America. Substance abuse, especially methamphetamine, makes child welfare problems more difficult. It increases the risk of abuse for example shaken baby syndrome and neglect. She said that a large number of out of home places are due the use of meth in the family. Other problems related are that one a child is removed from the home that family reunification is more difficult. When parents have a substance abuse problem, the children are often sick and the parent's can not get treatment or may also be incarcerated.

Ms. Richgels talked about obesity in rural children. She noted that it is very important to have collaboration in fighting childhood obesity. She spoke about the wellness and prevention activities within the HHS and USDA school feeding programs. She said spoke about the importance to help move forward the childhood obesity initiative led by Michelle Obama.

She said that there are four things that are needed for rural human services research and data collection. The four things needed are to define rural human services, understanding expected level of services, understanding the actual level of available services, understanding the impact of available and unavailable human services on health outcomes.

In the RUPRI human services panel statement, they were asked to understanding regional service delivery networks. Challenges ahead for state and local services providers are well documented by new ways to dealing with the budget crisis are not well known. She said that in their paper that they say, "These regional-centered systems could provide access to experience human service professionals with specialized awareness of federal and state assisted programs, as well as house non-profit organizations."

Ms. Richgels said that there is not a clear inventory of regional human services delivery networks and what the prerequisites are for success in widely dispersed rural locales.

Keith Mueller, Rural Policy Research Institute

Keith Mueller said that when he was asked to make a presentation to the committee he was going to be talking about the implementation of Health Care Reform. He said that he has been around policy enough to know to be prepared for change. He stated that the discussion points are around the discussions the RUPRI health panel has had around the issues that have surfaced in the reform discussions. He stated that this goes back to summer when the senate finance committee first published a series of white papers through the legislative proposals that passed in the senate and the house. He will be speaking more on a general level.

When thinking about the future he stated that there are three things that need to be considered and they are high level concepts, operational ideas and becoming part of the work flow of patient care and community health. He gave a scenario for the year 2025 in Sydney, Nebraska of a boy getting cold symptoms and his mom taking him to Wal-Mart because the store offers health care services. Those services are routine care, children and adolescent care, diagnostic testing, x-ray imaging, vaccinations and preventative care (taken from www.quickqualitycare.com/services.htm on August 11, 2006; current sites in Tampa, Stuart Fort Myers, FL).

Mr. Mueller compared the scenario of the boy in Sydney, Nebraska to the scenario of an 85 year old resident in Crawford, Nebraska in 2025 who has lived a healthy life and is covered exclusively by Medicare. Her arthritis is getting worse and she needs upgraded care. She can find a medical home 22 miles away in Chadron. She will have to purchase her medications at Wal-Mart or Safeway in Chadron and have 90 day supplies of some medicines mailed to her. She will have to rely on friend or neighbors to help her with day to day home care because there is no home health agency that serves her area. Her other choice would be to move to a community with more services.

He then gave a third scenario of the West Point, Nebraska health care system in 2025. It would be an integrated health care delivery system that give access to same day surgery performed by rotating surgical teams, 24/7 primary care in a local clinic, a local pharmacy and behavioral health services through a social worker with telehealth avail able. There would also be general surgery, delivery services and diagnostic imaging on site at the CAH. There would be assisted living and independent living supported by a regional nursing service. There would be a fully automated health information system and electronic health records.

He said that these are three potential scenarios of what the future of rural health care could look like in 15 years. He asked what some of the building blocks would be to help get to the most favorable scenario. There should be a framework that is based on the continuum of care in a rural areas and what services need to be available locally. Also, how to integrate services so that the health care system can service the patients needs even if the service itself is not done locally. He said that integrated care requires relationships among providers, information exchange and may be done by accountable care organizations.

Mr. Mueller noted that the workflow needs to include provider communication and the use of electronic records. There needs to be cross- provider relationship between RHC’s, CHC’s, hospitals, and skilled nursing and physician clinics.

He stated that care management needs to be patient centered and follow a primary care philosophy. To operationalize that it can be with a patient centered medical home, with electronic health records and by recruiting and retaining appropriate professionals and support staff. Mr. Mueller said a workflow should include training models for health professions and optimal use of personal health records.

Mr. Mueller talked about quality improvement and using the institute of Medicine's framework. He said that there needs to be a move forward through changes in the process of care and trying to encourage the changes. This can be made operational through value based purchasing, accountable care organizations, developing and implementing appropriate measures, developing systems of care and public reporting. Quality improvement workflow means that there needs to be decision support systems. Health professions training and implementation of appropriate process changes is vital. Patients need to be empowered and there need to be support services to patients.

Mr. Mueller stated that access to care means having the right service at the right place and the right time. It is an evolving picture but that is the ultimate goal. It is operational through regional system development, workforce planning and optimal care by providers practicing to their fullest capacities. Workflow issues can be benefited through the use of telehealth to move services, patient's movement to services and decision support.

He noted that affordable coverage is something that is important in the discussion of reform. There has been a policy boundary of market-based approaches to making coverage more affordable with a public safety net back up that is tailored to specific populations and places. To become operational there needs to be small businesses to participation in the market. A safety net for public program expansions is important. These are operational ideas that have immerged in the past two years. To have this workflow it requires communication with small business, matching benefits to needs and assisting persons acquiring insurance through exchange.

Mr. Mueller's closed by speaking on public health programming and the need for population based improvement, health living and wellness that extends beyond a medical model. To make this operational the local health departments need to be involved. A dissemination of best practices and tying programs to community goals is important. The workflow for public health programming will need to take a look at the infrastructure in the area. Other considerations include facilitating and enabling the health care leaders in a community to allow communities to think about broader issues of public health.

Q & A

John Rockwood asked about putting together a complete medical record no matter where a person goes for care. Who would be the Accountable Care Organization to make sure that the record is complete? How do you see that working in the future? How do we control the information so that it ends up in a comprehensive medical record?

Keith Mueller said that a vision is that there was a system that could query a national health information network about patients through identification. That is the vision of ONC. There are many ideas of how to get to the point. One idea is that the patient is the one that is the owner of the record. They could carry it on a card. The Department of Cardiology, with the Nebraska Medical Center, has developed that with all of their patients.

Todd Linden said that he thinks there is a role for community health leaders to promote wellness initiatives. He said that the only way they are viable for the communities to stay relevant and having an emergency department is a way to stay relevant. Helping people stay well and enjoy a good quality of life is the Community Hospital's role. It is in their best interest to have a healthy senior come in because the patient can be transferred quicker from an acute care setting.

Maggie Blackburn said that she thinks that having a personal health record is the best way. If the patients have their health information it will work well. What will have to be considered is how the information is entered and how it interfaces with various health agencies. They have to be able to work together. It needs to be considered that the products are proprietary and they do not communicate with each other unless someone writes the interface for them to work together.

Keith Mueller responded that putting systems in is one investment and getting systems to interact is a second investment. Small communities can not afford it so this is a real issue.

Maggie Tinsman first said that rural substance abuse is a major problem. She also asked if Jocelyn Richgels had done any research on rural human trafficking. Ms. Tinsman said that her husband has prostate cancer and does not always remember all of the information that the doctor tells him. How do they empower patients to remember that information? She said that she had to attend the visits also to know what the doctor has said.

Keith Mueller responded that at the community level, what are the ways of being proactive. Community resources are the patient empowerment. Something like a community health worker that becomes the patient advocate. This empowers the patient and their support network.

Sharon Hansen asked Jocelyn Richgels to define the regional center more. Jocelyn Richgel stated that regional has to be a self defined region for an area. She said that it is important that it does not become a regional system that is based in a metropolitan area. It needs to be centered in a non-metropolitan area. Sharon Hansen said that in North Dakota that human service centers are in the largest community within the planning region. She said that a lot of the families and children that need the services are at least a hundred miles from the center. They have tried to send workers out to the community.

Ms. Richgels said that in rural services they need to be thinking about mobile units. The alternative from a rural region system is going to the metropolitan areas.

Sharon Hansen asked how much research has been done on poverty and accessing childcare. She wondered if they are not accessing it because they do not know how important it is or because it is less available to people in poverty. She said that people in poverty are less likely to access licensed childcare because it is not available to them. Ms. Hansen said that she does not think there is that type of research but that she thought that it may be both reasons.

April Bender noted that the Workforce Investment Act caused people to pull their money from mobile services so there was no longer outreach in the rural community. It further removed the people in the rural communities. She said that it is important to look at the regional system and how the system works as opposed the “brick and mortar” approach.

Jocelyn Richgels said that there need to be some type of demonstration projects in rural to figure out the right avenue for regional service networks.

HIT Meaningful Use

Mike Neely, Office of Rural Health Policy, HRSA, DHHS

Mike Neely began by speaking about the relationship between ARRA and Meaningful Use. There is 19.2 Billion allotted for HIT within The Recovery Act. 2 billion is for ONC and 17.2 billion for incentives for Medicare and Medicaid Reimbursement Systems. It codified ONC, created the standards for ONC, provided grant and loan programs and there are privacy and security provisions that may lead to something similar to a HIPPAA II. There is 7.2 billion allotted for Broadband Technology with a little over 4 billion allotted for rural. 500 million went to SSA, 85 million to IHS and 50 million to VA.

There were three major titles within ARRA that affected the population relationship to HIT. There are Broadband Technology Opportunities Program, CMS incentive Programs and HITECH. Broadband Technology Opportunities Program breakdown is about improving access and the

goal is to increase the amount of Broadband. Broadband was not defined so it varies depending on what is being viewed.

Health Information Technology for Economic and Clinical Health Act gave 2 Billion to the Office of the National Coordinator. All of the funds have to be obligated by March 31, 2010. The four focus areas are Public Health Information Exchange, Health Professions, Health Information Exchange and Regional Extension Centers. Within HITECH there were eight sections that we condensed into the four priority areas.

The CMS incentives were divided into Medicare and Medicaid. Medicare had a different definition for providers. Medicaid incentives could expand out to providers to include other healthcare service delivery points. Everything in the incentives was Meaningful HIT Adoptions which is the meaningful use rule being acted on. The three criteria are the use of EHR, Information Exchange and reporting on measures using EHR.

Mr. McNeely said that the only group that can receive the Medicare funds is physicians. They get 75% of allowed Medicare charges for professional services for a payment year or yearly maximums. For PPS Hospitals they have until 2013 to get to meaningful use and receive full incentives. Penalties for non-users start in 2015. If you meet the standards set then the rule is to divide into the pre-imposed. The preliminary certifications and the final part are more stringent to meet what will be considered meaningful use. If you have a current system you would want to get it certified within the first two years.

Critical Access Hospital's that are meaningful users by 2011 are eligible for 4 years to get all of their incentives. He noted that for a CAH to be eligible at this point they would have to already be implementing electronic health records and be pretty far along in the process. He said that if you are an early adopter you lose out on the depreciation.

Mr. McNeely spoke about the Medicare Incentives for PPS hospitals. The base is 2 million adding the discharge payment and Medicare share. He said that for costs you get the total EHR costs multiplied the Medicare share plus 20%.

Medicaid eligible providers list includes physicians, nurse practitioners, nurse midwives, physician assistants, Rural Health Clinics, Federally Qualified Health Centers and Acute Care Hospitals. They have to meet the Medicare requirements but the state has the option to give guidelines on what is required to receive the Medicaid payments. Mr. McNeely said that the money is available this year. You have to be working towards meaningful use in the first year but if you do not meet the requirement by the end of the year, your funds are cut off. Providers can choose one or the other. If a provider chooses Medicare they can switch to Medicaid but the

time line is intact. You can only change one time. He said that eligible professionals can not be hospital based and must have a patient load of 30%. If the provider is a pediatrician, then patient volume must be 20% Medicaid and incentives will be take at 2/3 the rate.

Mr. McNeely spoke about meaningful use. He said there are three stages. Stage 1 is to get everyone up and running and create data collection. Stage 2 would include would have data exchange available and Stage 3 would have quality control and be able to affect outcomes. There are stages so that the policy counsel recommended that they use adoption years. They help in the first stages. They allow incentives if you adopt it from 2011 to 2013. Adoption year means you only have 2013 and 2014. Adoption year 2015, only has that year. It gives a break in the beginning but it has to be brought up quickly.

He stated that a meaningful user in relation to physician practices is that you have to an EMR, fully functional CPOE and have to be exchanging information. The interfaces and relations to CPOE are not required for the 2011 launch. Meaningful use incentive for physicians goes into affect calendar year 2011 but not fiscal year. For hospitals they will have to have 10% CPOE, which is computerized physician order entry.

The model being used is the HIM's model. When looking at the urban and rural breakdown, the vast majority of urban is 0-3 and the vast majority of rural is 0-2. If you look at CAH's verses PPS, the majority of CAH's are 0-1. The adoption rates in rural are significantly lagging. To go from 0-2 takes about 2 years. If most of rural is in a 0-2 and meaningful use is from 3 ½ to 4, it is going to take more time and that creates a divide.

He spoke about the issue of lack of access to capital is an issue. He noted that with the recession, banks are not loaning. He noted that regional lenders are seeing the meaningful use proposed rule being some that is helpful and safe to invest in.

Mr. McNeely spoke about the exclusion of Critical Access Hospitals in the Medicaid Incentives. ARRA indicates that Acute Care Hospitals are eligible for the Medicaid incentive. CMS has excluded Critical Access Hospitals from receiving Medicaid payments. CMS does not have a definition for an Acute Care Hospital so they use their CCN codes for identifying what an Acute Care Hospital would be and unfortunately CAH codes do not fall within the guidelines. The key is to learn about it and educate CMS. There was a belief that the Medicaid money would be utilized for CMS hospitals.

John Rockwood asked that if this can fund physicians and hospitals in rural areas, what criteria are you using to make sure that physician systems can talk to hospital systems, visa versa. He noted that the hospitals have a set of vendors that they can chose from but from they have a

group of physicians and surgeons, and that none could talk to one another or to the hospital. It was a waste of money. If trying to get to an integrated medical record, money is being thrown away.

Michael McNeely said that there was a matrix created of what has to be captured and the goal of statewide HIE is to make sure that everyone communicates.

Maggie Blackburn said that there can be a system that meets all of the requirements including order entry but it is being ordered to another entity and not necessarily the hospital. The two order entry systems do not even have to be talking to each other. You can meet all of those criteria and they all meet the codes and they do not talk to each other. She received that information from physicians in the rural communities when she sent out information on meaningful use.

Ms. Blackburn asked if for physicians and the percentage of Medicaid that he said that Pediatricians are 20% Medicaid and Adult Medicaid is 30% Medicaid to meet the criteria. Do family physicians get the 20% or the 30% for the percentage of Medicaid? Where would the family physicians fall? There are uninsured or underinsured and the underinsured may be self pay. That ends up being a hit for the provider. If you have practitioners, how do you account for that population?

Mr. McNeely said that the family practitioner would be treated as the adult and it would and be the Medicaid segment and go towards the 30%. The inner operability is on the state level HIE's to make sure those systems will communicate.

Committee Discussion (continued)

Recommendations for 2011 Report

Tom Morris started stated that bundling and ACO's was a topic that seemed to have the committee's consensus as a topic of interest. The rural consideration for Caring Communities for Young Children is a timely issue. It may not result in a concrete recommendation because it is really about getting people together across departments and cabinet level agencies. A rural angle in childhood obesity and another topic is telehealth. Mr. Morris said that they need to decide if telehealth would come before the other three topics.

Maggie Blackburn said that she would like more information on return on investment around telehealth. We need to look at the lack of broadband in many rural areas. Is there the infrastructure in the rural areas to support it and what will the cost be. Those are things that need to be considered before thinking about the reimbursement.

Tom Morris said that it may be an issue for a further date. He noted that they are just assuming the telehealth grants in their office this year. He said that they need to get further into the telehealth programs and then look at again next year.

April Bender said that the issue of duplication of overlap of services is futuristic. Funding will be cut in the future and we need to project into the next two or three years so we do not miss our opportunity. We need to be responsive now in looking at duplication of services.

Todd Linden asked what the vision is for the over all work product for the year. It seems that we are still focused on our three topics. We can pick on or two for the traditional report and some can be done with white papers or call to action topics. He said that he was not sure what they are narrowing down to.

Tom Morris said there will be three ways to inform the Secretary. The annual report, comment letters and white papers. Part of the discussion is thinking which ones fit where. Also, there is a timing issue. Childhood Obesity will be a multi-year topic. It could be done in the report. Caring Communities for Young Children may not be that timely. Payment bundling within the next five or ten years Medicare will end up. Telehealth is a long term subject. Duplication of services is being talked about now and it may not result in cuts in the next couple of years. If there is a situation where they begin cutting programs, the health centers would likely be the last ones cut.

Larry Otis said that if it is too big a picture that they can not get actionable items. Tom Morris said that overlap may be something to address in a white paper.

April Bender said that Mary Wakefield was talking about drilling down into the silos. There may be things in regulations that are creating silos and they may create duplication. Is there a way to write legislation to reduce the amount of natural silos that are being created?

Tom Morris said that in the overlap issue, there are no requirements when someone applies for a 330 grant that forces them to acknowledge another safety net provider in the area. It is the absence of regulations not the existence of them. He said that there are other ones that do promote the silos but we need to identify the program and then bring up the issue or it becomes too broad. The top three topics can be the annual report, the white paper, and then have in reserve the topic of overlapping services. In June we can move forward with a whitepaper on overlap but if a more critical topic emerges we can do it on that.

John Rockwood said that overlap issues could be incorporated under bundling and ACO's.

Karen Perdue said that there is a way to assign out some of the work and do a literature review on current barriers and challenges so it can be looked at next time or it can be re-evaluate at another time.

Tom Morris said that the Rural Assistance Center would like to partner with the committee. We could ask them to put together a package on the three issues. They would have information on overlap but the other two issues.

Tom Hoyer proposed the topic of barriers to integration.

Graham Adams said that if they address bundling and ACO's that they will be addressing the cooperation, competition issue. If people cooperate on how to split a payment they will be communicating more on the issue.

Maggie Tinsman said that 0-3 is the time period when the brain is still developing and it is very important who is impacting children during that time. Childcare is very important and who is taking care of the child during that time period. Rural areas have not had the emphasis on health, human services and education for 0-5 year olds and there could be concrete recommendations.

Larry Otis thanked the committee. He said that he understands that bundling and ACO's , Caring Communities for Young Children and the birth to eight agenda and Childhood Obesity are the topics to be looked at.

Tom Morris said that they can get information together about telehealth. There are many issues involved and it is far bigger than just telehealth at large. They are moving forward on the Administration on Aging reauthorization letter and meaningful use comment letter and hold the white paper to see where they are when they meet again in June.

The 2011 subcommittee assignments were made and the meeting was closed.

There was no public comment.

Friday, February 19, 2010

The meeting was convened by The Honorable Larry Otis, Vice Chair of the Committee.

Legislative Perspective

Congressional Staff Panel: Senate Rural Health Caucus, House Rural Health Coalition

The Committee also heard from a Congressional panel on key rural issues. Kate Anderson, a staff member with Senator Pat Roberts (R–Kansas) presented along with Melanie Rhinehart, a staff member with Rep. Earl Pomeroy (D–North Dakota). The two Congressional staffers discussed key issues the Congress would be dealing with over the coming year including rural Medicare payment extenders and adjustments to the Medicare physician fee schedule to address problems associated with the sustainable growth rate and the resulting payments cuts scheduled to take place.

The committee members voted to approve the 2010 Report to the Secretary.

Tom Morris asked the members to look at the Letter to the Secretary and let them know if they had touched on all of the issues. They are going to have the recommendations as an appendix in the letter. For the HIT meaningful use letter, if there is something missing or they want to emphasis one point over another, to let them know. If there is one point that is more important than another that they need that feedback. Dennis Dudley will follow up in April about the AoA comment letter.

There was no public comment. The Honorable Larry Otis closed the meeting.